The Royal Australian & New Zealand College of Psychiatrists

Victorian Branch

Your Health in Mind

RANZCP Victorian Branch

# 2026-2027 Victorian State Budget Submission

*Staying the Course: Safeguarding the Ambitions of Mental Health Reform*

# Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori. We honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

# Recognition of Lived and Living Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members and staff. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

# About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness, and advises governments on mental health care.

The RANZCP is the peak body representing over 8900 members in Australia and New Zealand and, as a bi-national college, has strong ties with associations in the Asia and Pacific regions.

The RANZCP Victorian Branch supports 2265 members across the state, including 1585 qualified psychiatrists and 680 psychiatrists in training and affiliates. Psychiatrists are clinical leaders in the provision of mental health treatment, care, and support and use a range of evidence-based treatments to support people in their journey of recovery.

# Notes about this submission

The recommendations contained within this submission are based on consultations within the RANZCP Victorian Branch membership and committees. We acknowledge that language, and the way we use it, can affect how people think about different issues. We acknowledge the need to give due consideration to the words we choose when communicating with and about people with a lived and living experience of mental health conditions. We recognise there are a variety of terms people prefer to use, such as 'client', 'consumer', 'patient', 'peer', and 'expert by experience'.

# Contact

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# Foreword

## *Staying the Course: Safeguarding the Ambitions of Mental Health Reform*

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Victorian Branch (the Branch) welcomes the opportunity to provide this submission to the Victorian Government ahead of the 2026–27 State Budget. We commend the Victorian Government's long-term vision and its sustained commitment to improving the mental health and wellbeing of Victorians. We also acknowledge the leadership provided by the Victorian Department of Health (Vic DH) in progressing reform during periods of significant workforce and system challenge.

Victoria's reform effort remains at a crossroads. The Royal Commission into Victoria's Mental Health System (RCVMHS) set out an ambitious blueprint for a responsive, equitable and recovery-focused system. While reform has achieved meaningful progress, momentum is slowing, workforce pressures are intensifying, while specialist and core clinical capabilities remain stretched. Psychiatrists across Victoria continue to report supervision gaps, workforce fatigue, and pressure on services that compromise continuity and recovery for those with a lived and living experience of mental health conditions.

Without sustained investment in the foundations of clinical care and system capability, there is a risk that critical reforms will stall, and the gains achieved since 2021 will erode.

Targeted, multi-year investment in workforce, clinical capability, digital infrastructure and statewide system design are required—to safeguard Victoria's mental health reform and deliver better outcomes for those with lived and living experience of mental health conditions, wherever they live.

This submission sets out seven practical investment priorities to sustain Victoria's mental health reform during the Reform 2.0 consolidation phase. Each reflects unfinished business from the RCVMHS, and the practical realities faced by clinicians delivering treatment, care, and support across the state.

The Branch looks forward to continued collaboration with the Victorian Government to ensure the delivery of a safe, responsive and recovery-oriented mental health and wellbeing system for all Victorians.

Yours sincerely,

**A/Prof Simon Stafrace**
*Chair, RANZCP Victorian Branch*

# Executive Summary

*Staying the Course: Safeguarding the Ambitions of Mental Health Reform* outlines seven investment priorities developed through consultation with Victorian clinical service leaders, the RANZCP Victorian Branch Committee, and partner organisations including Mental Health Victoria (MHV). Each reflects unfinished business from the RCVMHS and responds to practical realities faced by clinicians delivering care in a system under strain.

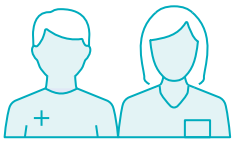
The Victorian Government's Reform 2.0 positions the mental health and wellbeing system for consolidation in a constrained fiscal environment. To "stay the course", however; Victoria will need targeted, multi-year investment in the clinical pillars of the RCVMHS, including the psychiatry workforce pipeline, Mental Health and Wellbeing Locals with clinical treatment capability, crisis alternatives, rehabilitation and recovery, integration with alcohol and other drug (AOD) treatment, digital infrastructure, and a renewed focus on statewide specialist services. These must be underpinned by clear accountability and regional planning through the implementation of the new Local Health Service Network (LHSN) governance structure to ensure reform momentum is not lost.

## *Key Recommendations*

1. Securing the Psychiatry Workforce Pipeline
2. Embedding Clinical Care in Mental Health and Wellbeing Locals
3. Expanding Crisis-Care Alternatives to Emergency Departments
4. Delivering Rehabilitation and Recovery Pathways
5. Integrating Mental Health and AOD Treatment, Care and Support
6. Driving Digital and IT Infrastructure Investment
7. Restoring and Stabilising Statewide Specialist and Tertiary Services

# Framework for Reform

To sustain reform momentum and deliver equitable, recovery-focused care, Victoria's mental health system must strengthen its foundations across two interconnected pillars — Workforce and Capability, System and Clinical Architecture, and a cross-system enabler, Digital and IT Infrastructure. Together, these pillars and seven priorities outline the targeted investments needed to "stay the course" on the RCVMH's vision and safeguard the gains already achieved.



## *Pillar 1: Workforce and Capability*

**Build and sustain the people who deliver treatment, care, and support.**

**Priority 1**: Securing the Psychiatry Workforce Pipeline

**Priority 5**: Integrating Mental Health and Alcohol and Other Drug (AOD) Treatment, Care and Support.

## *Pillar 2: System and Clinical Architecture*

**Embed continuity, equity and accountability across tiers of care.**

**Priority 2**: Embedding Clinical Care in Mental Health and Wellbeing Locals

**Priority 3**: Expanding Crisis-Care Alternatives to Emergency Departments

**Priority 4**: Delivering Rehabilitation and Recovery Pathways

**Priority 7**: Restoring Statewide Specialist and Tertiary Services

## *Cross-System Enabler – Digital and IT Infrastructure*

**Strengthen safety, integration and efficiency through secure, interoperable, workforce-led technology.**

**Priority 6**: Driving Digital and Infrastructure Investment

# Priority 1: Securing the Psychiatry Workforce Pipeline

## *Staying the course depends on a strong workforce pipeline. Stabilising psychiatry training and supervision is essential to meet community mental health needs now and into the future.*

Demand for specialist mental health care continues to rise, driven by population growth, increasing service complexity, and structural reform through Locals and the emerging LHSNs. Since the release of the RCVMHS Final Report, Victoria has almost doubled its first-year psychiatry registrar intake — a major milestone that reflects strong policy intent to rebuild the specialist workforce for the benefit of Victorian communities. However, the training pipeline remains fragile.

While Reform 2.0 emphasises consolidation, embedding and stabilisation, short-term funding and fragmented accountability continue to undermine psychiatry training and supervision. Clinical leaders report supervision cancellations, insufficient protected time, and escalating workloads.

Directors of Training (DoTs) and Directors of Advanced Training (DoATs) operate under short-term, administratively complex arrangements that do not reflect accredited training requirements, rising supervision intensity or increasing trainee numbers. Even when Hospital/Service Coordinators of Training (HCT/SCoTs) are included, supervision funding remains below College standards, creating material risks to training quality, accreditation, and workforce sustainability. SIMG Directors of Training — essential for the safe transition of internationally trained psychiatrists — remain precariously funded.

Several Victorian regions have more than doubled or tripled registrar numbers with no corresponding increase in EFT for supervision or administrative support. Some regional programs have grown from one to 21 registrars over the past decade; however, consultant departures have exposed how vulnerable supervision structures have become. It is unclear whether the rapid rollout of Locals and the establishment of LHSNs have been assessed for their impact on training funding, workload or governance.

Year-to-year funding cycles and unpredictable co-contributions further destabilise planning, and limit training capacity. A shift to a ring-fenced, five-year baseline for psychiatry training — including supervision EFT — would protect the integrity of the training pipeline, enable sustainable workforce planning, and ensure Victoria can meet future population needs.

Rising service co-contributions for intern and HMO (prevocational) positions have already led some health services to withdraw psychiatry rotations—undermining RCVMHS Interim Recommendation 7; and weakening early medical career exposure to mental health. Mandatory PGY1–2 psychiatry rotations remain one of Victoria's most effective recruitment pathways; 87% of first-year trainees commencing in 2026 had completed a prevocational rotation, demonstrating their importance in attracting and preparing the future workforce.

Strengthening mental-health care capability across the broader health system is also essential. Many Victorians first present to primary care, emergency departments or non-mental-health teams, where early, informed intervention can prevent deterioration and reduce demand on crisis and acute services. Expanding structured mental-health upskilling for GPs, emergency physicians and other community-based clinicians — including access to the RANZCP Certificate of Postgraduate Training in Clinical Psychiatry — would support early intervention, shared care and equitable access to treatment, care and support across Victoria.

Without stabilisation, these pressures will erode training quality, reduce retention of experienced psychiatrists, and constrain the state's capacity to meet community mental health and wellbeing needs.

# Recommended Government Investment

| Budget Ask | Recommended Government Investment | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Stabilise psychiatry training program funding** | Commit to a consistent, five-year ring-fenced baseline funding allocation for psychiatry training, including three years fully funded without requiring co-contributions, with EFT for DoT/DoAT/SIMG DoT aligned to trainee numbers and supervision benchmarks | Enables long-term planning, protects training funds from diversion under emerging LHSN models, and provides the scaffolding required to maintain accredited training quality. Aligns with RCVMHS Interim Rec 7 and the National Mental Health Workforce Strategy. | Operational Expenditure (OPEX), 5-year forward estimates. |
| **2. Stabilise prevocational JMO psychiatry rotations** | Restore and maintain prevocational (PGY1–2) psychiatry rotations across all regions; prevent losses associated with rising co-contribution requirements. | Builds system-wide mental-health capability and maintains a critical recruitment pathway (87% of 2026 trainees completed a JMO rotation). Aligns with RCVMHS Interim Rec 7. | OPEX, recurring baseline. |
| **3. Strengthen system capability for supervision and oversight** | Fund LHSN-based training governance and reporting capacity to support quality assurance, data, and cross-site supervision models (including for training places in Locals). | Embeds psychiatry workforce development within LHSN governance; improves accountability and consistency across regions. | OPEX, integrated within LHSN reform funding, 2026-31. |
| **4. Embed system-wide clinical mental-health capability** | Expand structured psychiatry upskilling (e.g. RANZCP Certificate of Postgraduate Training in Clinical Psychiatry) for GPs, ED doctors and other medical specialists, prioritising regional, outer-metro and high-acuity community settings. | Improves early intervention and shared-care capacity across Victoria's health system; supports prevention and timely response for the one-in-five Victorians experiencing mental-health challenges each year. Aligns with RCVMHS aims of whole-system capability uplift. | OPEX, small grants program, scalable program 2026–30. |

## *Expected Outcomes of Investment*

- System-wide uplift in mental health capability—improving early identification, safe referral, and continuity of treatment, care, and support across Victoria.
- A stable, five-year higher quality psychiatry training program; with protected and strengthened supervision structures and capacity as well as reduced administrative burden.
- Improved access to training positions, particularly in regional and rural areas, supporting RCVMHS workforce targets.
- Improved retention of clinical psychiatrists and strengthened service capacity across AMHWS, Locals and primary care.

# Priority 2: Embedding Clinical Care in Mental Health and Wellbeing Locals

*Embedding clinical standards and multidisciplinary capability in Locals is essential to deliver Reform 2.0 objectives—ensuring continuity, accountability, and equitable access to treatment, care, and support across Victoria.*

The RCVMHS Final Report envisioned Mental Health and Wellbeing Locals (Locals) as integrated, community-based Level 4 services for the "missing middle", combining psychosocial and clinical treatment, care and supports, where people live. Locals were designed to operate under shared governance with Level 5 Area Mental Health and Wellbeing Services (AMHS) and primary care.

In our submission to the initial Victorian Department of Health consultations the Branch highlighted the importance of multidisciplinary teams (MDT) (allied health, peer, psychology, psychiatry, social work, nursing), and the inclusion of lived and living experience leadership. This is to ensure a range of skills and expertise are available to deliver evidence-based treatment, care, and support that meets the mental health and well-being needs of Victorians, where they live.

In recent Branch consultations, Clinical leaders report that where Locals are co-designed and led by those with a lived and living experience, integrated with local AMHS, and governed with defined clinical teams and clear escalation pathways; there is improved access to treatment, care, and support for those with a lived and living experience of mental health conditions, and a reduced demand on acute services.

However, community mental health outcomes and services, including clinical components, are not consistent across the state. In addition, some of the recently announced "spoke" sites are funded at approximately one-quarter of the original model, raising concerns this will limit capacity to deliver safe, evidence-based clinical care. Inconsistent standards, variable escalation pathways and weak clinical frameworks risk undermining the RCVMHS Final Report's vision of equitable, MDT models of care, and access to community-centred treatment, care, and support.

As LHSNs assume commissioning and governance roles, Locals must be safeguarded as multidisciplinary, clinically accountable services, supported by strong psychosocial programs. This requires embedding statewide clinical standards, supervision frameworks, and defined training pathways within LHSN governance. Doing so will ensure Reform 2.0 consolidates progress and delivers continuity, accountability, and measurable outcomes for Victorian communities.

# Recommended Government Investment

| Budget Ask | Recommended Government Action | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Establish and enforce statewide clinical framework for Locals** | Publish a Vic DH-endorsed clinical governance framework specifying minimum psychiatrist, nurse, and allied-health staffing ratios; escalation and referral protocols; and quality-assurance processes across all Locals. | Ensures Locals deliver the intended RCVMHS Level 4 clinical-psychosocial model; supports consistency and safety across LHSNs. (RCVMHS Rec 3 & 11) | OPEX, 3–5 years. |
| **2. Resource Locals to operate at intended capacity** | Fund Locals to full service-model benchmarks; ensure no-wrong-door access and capacity for both face-to-face and outreach clinical care. | Restores alignment to RCVMHS vision; reduces ED presentations and demand on Level 5. (RCVMHS Rec 3) | OPEX, recurrent. |
| **3. Embed training and supervision capacity** | Accredit Locals for registrar placements and fund protected supervisor time; include structured LHSN oversight of supervision quality. | Builds workforce and service integration; Strengthens availability of access to specialist community treatment, care and support, where people live. Improves community training experience for psychiatrists. (RCVMHS Interim Rec 7) | OPEX, integrated with workforce funding, 5-year horizon. |
| **4. Strengthen GP and primary-care interfaces** | Fund AMHS Level 5 consultation-liaison clinics to provide primary/secondary consults, shared-care planning, and defined referral pathways back to Locals and GPs. | Enhances continuity between Locals, AMHS and GPs; supports early intervention. (RCVMHS Rec 11) | OPEX, 3-year pilot with evaluation. |

## *Expected Outcomes of Investment*

- Consistent statewide clinical and governance standards for Locals.
- Improved access to locally responsive MDT care in local communities.
- Clear escalation pathways and shared accountability across partner agencies.
- Strengthened community registrar training, supervision and local workforce capability.

# Priority 3: Expanding Crisis-Care Alternatives to Emergency Departments

*Expanding crisis-care alternatives is essential to deliver a coherent, statewide continuum of care—reducing ED reliance, improving equity, and ensuring models are funded, evaluated, and integrated with Locals and acute services.*

Emergency departments (EDs) across Victoria remain under increasing pressure. Mental health presentations have increased in both volume and acuity, including an increasing number of serious mental health presentations since 2020–21. While the RCVMHS Final Report called for a broader continuum of crisis response services the rollout has been uneven. Access to short-stay, Hospital in the Home (HITH), and crisis-hub capacity varies widely, with access and equity particularly strained in regional areas. In addition, not all models have consistent funding or evaluation frameworks, or workforce supply.

Clinical leaders report flow is increasingly affected by prison-to-ED transfers, homelessness and housing instability—factors that drive repeat presentations and unsafe discharges. Alternative models such as crisis hubs, short-stay units, and Safe Havens have begun to provide more appropriate options. Evidence from Victorian services shows that lived experience-led services with on-site clinical support can improve experience and reduce distress of those with a lived and living experience of mental health conditions, though impacts on overall ED volume remain modest.

By contrast, crisis hubs and short-stay units provide clearer clinical value for brief admissions, detoxification and stabilisation. Access however remains patchy—particularly in regional Victoria—and not all models have consistent evaluation, funding or workforce frameworks. During consultations, clinical leaders have also highlighted the need to build the community crisis capability of existing community teams including single-session family work and peer support, to prevent hospital escalation.

To plan effectively and coherently, transparent statewide bed modelling is essential, ensuring crisis alternatives, acute units and rehabilitation (Recommendation 12) are commissioned as part of a single continuum. Without this, crisis models risk operating in isolation from Locals, acute mental health services, as well as recovery and rehabilitation pathways.

# Recommended Government Investment

| Budget Ask | Recommended Government Action | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Scale evidence-supported crisis alternatives** | Expand crisis hubs and short-stay units; co-designed lived-experience-led with clinical support; up-skill community teams to provide intensive crisis responses. | Provides timely, appropriate alternatives to EDs, reducing distress and hospital demand. RCVMHS Recs 8–10. | Recurrent OPEX + capital for new hubs, 2026–31 |
| **2. Establish regional consultation-liaison telehealth networks** | Fund telehealth consultation and escalation pathways from non-designated EDs to AMHS; ensuring defined hours, governance, and clinician access for assessment and advice. | Improves safety and equity in regional and rural crisis responses; provides early specialist input and support. RCVMHS Recs 8, 10. | Recurrent OPEX, 2026–31 |
| **3. Integrate AOD and housing supports in crisis pathways** | Embed AOD clinicians and liaison roles within crisis hubs and short-stay services; link with housing and psychosocial programs to enable safe discharge. | Reduces repeat presentations and supports recovery-oriented transitions post-crisis. RCVMHS Recs 8–12. | Recurrent OPEX, 2026–31 |
| **4. Publish statewide bed modelling, build and implement systems** | Release transparent modelling across crisis, acute, sub-acute/short-stay, SECU/CCU and PARC beds to guide commissioning, ensure flow and inform regional capacity targets. | Builds system coherence, provides evidence-based planning and transparency for capacity, flow and equity-including regional planning and outcomes. (RCVMHS Recs 8–12) | OPEX Analytical + capital planning funding, 2026–28<br><br>One-off OPEX 2026–28 |

## *Expected Outcomes of Investment*

- Consistent statewide clinical and governance standards for Locals.
- Improved access to locally responsive MDT care in local communities.
- Clear escalation pathways and shared accountability across partner agencies.
- Strengthened community registrar training, supervision and local workforce capability.

# Priority 4: Delivering Rehabilitation and Recovery Pathways

*Restoring statewide rehabilitation and recovery services is critical to deliver Recommendation 12 and Reform 2.0 objectives—ensuring equitable access to multidisciplinary, least-restrictive care, integrated with housing and psychosocial supports.*

The RCVMHS Final Report Recommendation 12 called for the redesign of rehabilitation and recovery services to meet contemporary mental health and wellbeing needs of the Victorian community. Four years on, progress has stalled. Victorians with complex and enduring mental illness continue to miss out on the treatment, care, and recovery supports needed to live well in the community.

Clinical leaders across the state report widening inequities between regions, with too many rehabilitation services no longer fit for purpose. Outdated facility design compromises safety, limits participation, and constrains efforts to eliminate restrictive practices. Inequitable access to Secure Extended Care Units (SECUs), Community Care Units (CCUs), and subacute step-down services has created a postcode lottery for rehabilitation and recovery.

Clinical service leaders across Victoria raised serious concerns about gaps in rehabilitation pathways during Branch consultations, particularly for individuals who are too high-risk for AMHS but not suited to forensic inpatient care. This leaves a small, high-risk group without appropriate treatment or support options. Recent SECU referral data from Austin Health reinforces these concerns, highlighting the psychosocial and physical complexity of patients, with diverse needs, service goals, and elevated psychiatric and interpersonal risk prior to admission.

To address these gaps, Victorian services are calling for renewed investment in intensive, multidisciplinary, community-based rehabilitation models, including Prevention and Recovery Care Services (PARC), with strengthened forensic input and security staffing in SECU/CCU settings. These models enable evidence-based treatment, care, and support, while reducing hospitalisation, preventing reoffending, and promoting long-term recovery and reintegration.

Victorian's experiencing complex and enduring mental illness are among our most disadvantaged, with heightened exposure to adverse social, economic, and environmental conditions that impact mental health.

Housing instability was identified by Victorian clinicians as a critical issue contributing to chronic ill-health, violence exposure, and long-term unemployment—factors that exacerbate depression, anxiety, and psychosis. The absence of integrated psychosocial and housing supports—linked with broader health and housing systems—disrupts recovery, continuity of care, and access to essential services. Addressing these determinants is vital to breaking cycles of acute care, homelessness, and justice involvement.

A modern rehabilitation and recovery system that reflects community experiences, needs and preferences is essential to reform success. Without structured rehabilitation alongside stable housing—too many vulnerable Victorians are at risk of cycling through acute care, homelessness, and potentially justice involvement. A modern system must guarantee all Victorians early access to high-quality, least-restrictive care within their local communities, delivered in environments that foster recovery, healing, independence, and community participation. Restoring a coordinated statewide rehabilitation and recovery network—supported by workforce, infrastructure, and improvements to how services are planned, funded, and delivered—will ensure equitable, safe, and recovery-focused services across Victoria.

# Recommended Government Investment

| Budget Ask | Recommended Government Action | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Implement RCVMHS Rec 12 through a statewide rehabilitation blueprint** | Define SECU/CCU functions, admission criteria, lengths of stay and step-down pathways; establish a medium-secure stream for those with a lived and living experience of mental conditions too complex for AMHS but below forensic thresholds. | Restores a coherent rehabilitation and extended-care system with clear flow and access. RCVMHS Rec 12. | OPEX + CAPEX, 5-year staged plan. |
| **2. Rebuild community rehabilitation capacity** | Fund discipline-specific MDT programs with integrated physical health and therapeutic activity; embed outcome measurement. | Strengthens recovery-focused community rehabilitation and reduces reliance on inpatient beds. RCVMHS Rec 12. | OPEX, recurrent. |
| **3. Modernise rehabilitation infrastructure** | Replace or refurbish unfit facilities (CCUs, PARCs) to meet safety and design standards that support recovery and reduce restrictive practice. | Improves safety, dignity and therapeutic value of rehabilitation environments. RCVMHS Recs 11 & 12. | CAPEX, multi-year capital program. |
| **4. Strengthen psychosocial and housing supports** | Scale interim psychosocial programs and expand supported housing models—integrated with broader health and housing supports addressing social determinants of health—to unblock discharge and sustain recovery, while continuing collaboration with the Federal Government on national reforms. | Reduces revolving-door admissions and supports stable recovery in the community, consistent with RCVMHS 11 and 12. | OPEX, 3–5 years, integrated with the Victorian housing portfolio. |

## *Expected Outcomes of Investment*

- Victorians who experience complex and enduring mental health conditions receive consistent, recovery-oriented care in their community.
- Safer, modern facilities that support therapeutic engagement and enable least-restrictive practices.
- Reduced acute bed pressure and repeat admissions.
- Strengthened MDT rehabilitation workforce and integrated housing and psychosocial supports.

# Priority 5: Integrating Mental Health and Alcohol and Other Drug (AOD) Treatment, Care and Support

*Embedding integrated governance, shared clinical standards, and co-commissioned models is essential to deliver Reform 2.0 and the Victorian AOD Strategy—ensuring equitable, evidence-based care for people with co-occurring needs.*

The RCVMHS Final Report called for integrated, person-centred care, however, availability and service integration between mental health and AOD programs continues to remain uneven across Victoria. Some regions have developed strong local partnerships and embedded AOD clinicians within mental health teams, while others rely on informal referral and limited shared governance.

We note that as part of a Statewide Action Plan to reduce drug harms, the Victorian Government is developing a long-term AOD Strategy. The Branch and Mental Health Victoria (MHV), in consultation with clinical leaders; developed and delivered a joint policy position to ensure strong clinical input informs that strategy and related commissioning. Sector feedback shows rising co-occurring need, significant variation in models and resourcing across services, and inconsistent governance for dual-diagnosis care across the Victorian community.

Victorian guidance already envisages integrated treatment, care and support for people with co-occurring mental health and AOD needs, delivered across settings according to need and intensity; however, implementation remains uneven. The joint RANZCP–MHV position provides a practical integration framework to guide government and LHSNs as they consolidate Reform 2.0.

# Recommended Government Investment

| Budget Ask | Recommended Government Action | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Build dual-diagnosis capability in core services** | Fund embedded AOD clinicians and psychiatry consultation-liaison in AMHS and Locals; provide reciprocal AOD–MH training, supervision and practice support. | Strengthens workforce skills and collaboration; improves the lived and living experience of mental conditions safety and outcomes. RCVMHS Recs 8–10, 42. | Recurrent OPEX, 2026–31 |
| **2. Strengthen crisis and recovery pathways** | Integrate AOD capacity within crisis hubs, short-stay and rehabilitation services (Rec 12), ensuring access to detox/withdrawal and step-down supports linked to housing and psychosocial care. | Provides continuity across crisis, acute and recovery settings; reduces revolving-door presentations. RCVMHS Recs 8–12. | Mixed OPEX + minor CAPEX (for co-located services), 2026–31 |
| **3. Align commissioning, data and performance** | Establish joined performance measures and shared information systems (e-referral, data linkage) across MH–AOD contracts, overseen through LHSN governance. | Enables system-wide accountability and visibility of outcomes; supports evidence-based planning. RCVMHS Recs 11, 42. | OPEX (analytic + system investment), 2026–29 |

## *Expected Outcomes of Investment*

- Improved access to coordinated dual-diagnosis, evidence-based treatment and recovery supports.
- Reduced ED presentations and acute relapses linked to AOD use.
- Strengthened workforce capability in dual diagnosis across AMHS and Locals.
- Better alignment of data, accountability and outcomes across MH–AOD systems.

*Cross-System Enabler – Digital and IT Infrastructure*

# Priority 6: Driving Digital and IT Infrastructure Investment

## *Modern digital tools are essential for delivering safe, coordinated specialist treatment, care and support. Outdated systems reduce therapeutic time and widen inequities.*

Digital capability and fit-for-purpose IT infrastructure underpin workforce therapeutic availability, clinical safety, workforce sustainability and system integration. Yet Victoria's mental health services continue to operate with fragmented IT systems, variable digital literacy, and unclear indemnity and practice standards. The Branch recognises that digital systems and modern facilities are now core enablers of safe, effective and equitable mental health care — consistent with Victoria's Reform 2.0 agenda and the Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017–2037.

As artificial intelligence (AI) and automation tools emerge, the mental health and wellbeing system must lead a safe, ethical and clinically meaningful adoption, to ensure they enhance rather than erode therapeutic relationships. Telehealth has become indispensable for psychotherapy, supervision and regional access; but requires sustained funding, data protection and interoperability with health record systems.

Investment in digital and IT infrastructure is a strategic technology cost that delivers returns by enabling productivity. Streamlined documentation, interoperable systems, and AI-assisted administrative tools directly enhance workforce availability for treatment, care, and therapeutic engagement. This leads to improved mental health and wellbeing outcomes for the Victorian community, strengthens safety, and reduces duplication across the system—delivering measurable efficiency gains aligned with Reform 2.0.

# Recommended Government Investment

| Budget Ask | Recommended Government Action | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Develop a statewide digital-practice framework** | In consultation with the RANZCP, fund the Vic DH to set clinical, ethical and technical standards for telepsychiatry, digital psychotherapy, supervision and AI use. | Ensures safe, consistent and defensible digital practice; embeds digital enablement as a clinical infrastructure priority. RCVMHS Recs 11, 42. | OPEX (policy + standards development), 2026–28 |
| **2. Fund secure, interoperable digital infrastructure** | Invest in interoperable electronic medical records, e-referral and data-sharing systems linking AMHS, Locals, private psychiatrists and statewide services. | Enables shared care, reduces duplication and supports integrated service pathways. RCVMHS Recs 11, 42. | Capital Expenditure (CAPEX) + OPEX (implementation + maintenance), 2026–31 |
| **3. Pilot AI-assisted EMR tools with safeguards** | Trial ambient transcription and administrative automation tools with embedded privacy, consent and governance oversight. | Builds productivity and releases clinician time for direct care while protecting the rights of those with a lived & living experience of MH conditions. RCVMHS Rec 42. | OPEX (pilot + evaluation), 2026–29 |
| **4. Embed digital and IT infrastructure in capital planning** | Require all new or upgraded mental health facilities under LHSN reforms to include digital integration and telehealth capability. | Aligns physical and digital investment; ensures system-wide connectivity and modern standards. RCVMHS Recs 11, 42. | CAPEX (capital planning integration), ongoing 2026–31 |

## *Expected Outcomes of Investment*

- Increased workforce availability for therapeutic engagement.
- Modern, digitally connected infrastructure supporting safe, efficient and integrated care
- Improved clinician productivity and reduced burnout through reduced administrative burden and increased streamlined documentation and communication systems.
- Secure digital systems enabling shared care across public, private and community sectors.
- Equitable access to telehealth, digital therapies and clinical supervision across Victoria.

# Priority 7: Restoring Statewide Specialist and Tertiary Services

*Restoring statewide specialist services is critical to prevent access being shaped by postcodes and pockets rather than community need—ensuring ring-fenced funding, defined roles, and integrated digital connectivity will deliver Reform 2.0's equity promise.*

Victorians experiencing complex and enduring mental health needs should be able to rely on a functioning statewide specialist layer (Level 6) to receive timely, evidence-based care, irrespective of postcode. When funded correctly, this health service layer secures equitable access to low-volume, high-complexity treatment, care, and support across Victoria and anchors consistent pathways between crisis, acute, rehabilitation and community services. Victoria's Reform 2.0 consolidation phase demands decisive action to maintain a robust statewide specialist tier. Without it, we risk fragmentation, eroding clinical standards, and failing to deliver on the reform's equity promise.

Clinical leaders report rising demand and widening inequity as statewide specialist mental health programs—including trauma, neuropsychiatry, eating disorders, personality disorder, perinatal, forensics, and the statutory Second Psychiatric Opinion Service (SPOS)—absorb growth without matched resourcing. Service capacity has not kept pace with population needs or reform expectations. Reportedly, funding for several specialist functions has been reduced or absorbed, undermining the integrated, consistent, and equitable model for which Victoria has been widely regarded as national best practice. In addition, the absence of published, transparent statewide bed modelling—for crisis hubs, short-stay units, acute beds, SECUs/CCUs, and PARC units (see Priority 3)—continues to hinder coherent and strategic commissioning.

The statewide trauma service, established as Transforming Trauma Victoria (TTV), for example, remains underdeveloped despite increasing community need for essential integrated trauma care across mental health, AOD, and physical health systems. This represents a system-level gap that must be addressed through funding TTV as a fully realised statewide trauma mental health service with clinical, educational and research functions. Another example is the expansion at Thomas Embling Hospital, which has reportedly stalled due to workforce and funding intensities and complexities, as demand within prison consumes capacity.

New and emerging specialist needs also warrant attention — particularly the mental health and wellbeing needs of neurodiverse individuals, including those with ADHD and autism, who currently face extensive wait times and costs, and fragmented care. Investment in specialist neurodiversity outpatient clinics within AMHS would enable equitable access, foster best practice, and create structured training opportunities for registrars, nurses, allied health, and peer workers in this fast-growing clinical domain.

Restoring and expanding these services is not optional—it is critical to protect hard-won gains and guarantee that people with complex needs receive the best available specialist treatment, care, and support wherever they live. Additionally, as LHSNs take shape, statewide programs must be equipped with clearly defined roles, long-term ring-fenced funding, and seamless digital connectivity. This is essential for providing expert consultation and liaison to regional services and delivering direct treatment, care, and support where people live.

The call to action is clear: commit now to securing the statewide specialist tier as a cornerstone of reform. Without this commitment, the promise of equity and excellence will not be realised.

# Recommended Government Investment

| Budget ask | Recommended Government Investment | Purpose & Alignment | Indicative Funding Type & Cost Horizon |
|---|---|---|---|
| **1. Stabilise and uplift statewide specialist programs** | Reinstate and expand operational capacity for trauma, perinatal, neuropsychiatry, forensics, eating disorder, and personality disorder services; ring-fence Level 6 budgets; set service-specific KPIs (access times, outcomes, regional consults). | Restores and protects core statewide capability to manage complex, low-volume care; maintains statutory SPOS capacity. RCVMHS Recs 11, 12 & 42. | Recurrent OPEX 2026–31 (+ evaluation fund 2026–28) |
| **2. Establish statewide neurodiversity outpatient clinics** | Fund dedicated outpatient clinics within AMHS for neurodiverse individuals experiencing co-occurring mental health problems, including ADHD and autism. Ensure timely access, promote consistent evidence-based care, and provide structured training for registrars, nurses, allied health and peer workforce. | Addresses major and growing community unmet needs and fulfil key RCVMHS reform commitment. RCVMHS Recs 11 & 12. | Recurrent OPEX 2026–31 + CAPEX (infrastructure and systems), staged 3-year plan 2026-29. |
| **3. Embed statewide services in LHSN and digital planning** | Define governance, referral pathways and digital interoperability (including telehealth) between statewide hubs, AMHS and Locals; | Ensures statewide services remain visible and connected within LHSN structures through alignment of data, infrastructure and accountability frameworks. RCVMHS Recs 11 & 42. | CAPEX + OPEX, 5-year digital integration program. |
| **4. Leverage statewide services as training and research hubs** | Expand registrar rotations, supervision networks and specialist curricula; | Supports innovation and system learning through embedded evaluation. Linked RCVMHS Recs 11, 12 & 42. | Recurrent OPEX 2026–31 |

## *Expected Outcomes of Investment*

- Improved outcomes for those with a lived and living experience of mental health conditions through earlier, specialist-led intervention.
- Restored statewide specialist capability ensuring equitable access across Victoria.
- System coherence through published capacity baselines and targets.
- Reduced system fragmentation and clearer referral pathways for complex treatment, care, and support.
- Stronger statewide hubs for training, supervision, research, innovation, and practice improvement.
- Transformation of Trauma Victoria into a leading trauma mental health service linking clinical care, training, and research—envisioned by the RCVMHS.

# Staying the Course: Safeguarding the Ambitions of Mental Health Reform

Victoria's mental health and wellbeing reform stands at a pivotal juncture. The system's long-term success depends on stabilising the clinical workforce, embedding consistent standards across service tiers, and investing in the infrastructure that supports safe, connected, and accountable treatment, care, and support.

The priorities outlined in this submission reflect psychiatry's contribution to a responsive, evidence-based system that delivers the best outcomes for people with a lived and living experience of mental conditions within the Victorian community.

With targeted, multi-year investment and continued collaboration between government, services and the profession, Victoria can stay the course — realising the Royal Commission's vision of an equitable, high-quality mental health and wellbeing system for all Victorians.

Royal Australian and New Zealand College of Psychiatrists – Victorian Branch
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